



**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
CIO BUREAU/SYSTEMS AND OPERATION/HELP DESK**

INDIVIDUALS AUTHORIZED TO SIGN CIOB FORMS

☐ **New**

☐ **Replace Signatures on File**

☐ **Add to Signatures on File**

Legal Entity # _____

Check Box for Type

Reporting Unit (s): _____ ☐ DMH ☐ NGA ☐ FFS ☐ DHS

Provider/Agency Name: _____

Address: _____
Street City State Zip

Telephone Number: _____
Area Code Number Extension

Director/CEO Level or Above: _____
Print/Type

Title: _____

Director/CEO Level or Above Signature: _____

Director's E-Mail Address: _____

**The following individuals are authorized to sign CIOB Forms submitted by the
above name agency:**

Name of Designee: _____
Print/Type

Signature of Designee: _____

Title: _____ Phone: _____

E-Mail Address: _____

Name of Alternate: _____
Print/Type

Signature of Alternate: _____

Title: _____ Phone: _____

E-Mail Address: _____

Date Submitted to CIOB _____

NOTICE: FAX WILL NOT be accepted. Original signatures are required.

Return completed form to: LA County, Department of Mental Health
CIO Bureau/IS-Systems Access Unit
695 S. Vermont Avenue,
Los Angeles, CA 90005